**Aisef Ahmed**

**02/22/2026**

**Long-term Care Rotation**

## H&P #1

**Chief Complaint:** "Productive cough for 2 days."

**History of Present Illness**

Mr. G.W is a 77-year-old male with PMHx significant for HLD, atrial fibrillation, HTN, BPH, and pre-diabetes who was initially admitted to NYP Lower Manhattan Hospital ED for right flank pain and found to have a 7 mm obstructing right ureteral stone with grade 4 vesicoureteral reflux. NYP Lower Manhattan Hospital attempted a cystoscopic right ureteral stent placement on 2/13/2026, however was unsuccessful due to the inability to identify ureteral orifices. He was transferred to NYP Weill Cornell for the right percutaneous nephrostomy (PCN) tube placement due to concern for obstructive pyelonephritis.

Mr. G.W is now admitted to subacute rehabilitation at Gouveners Health on 02/28/2026 for continued monitoring status post percutaneous nephrostomy tube placement and recovery from obstructive pyelonephritis. On admission Patient reports a 2-day history of productive cough with clear sputum, rhinorrhea, and watery conjunctival discharge. He also reports new fluid -filled vesicular lesions with crusting on the upper lip. Additionally, localized right flank discomfort, which he describes as "dull Aching" above the PCN site, and expressed pain of 2/10. He denies fever, chills, nausea, vomiting, diarrhea, dysuria, hematuria, chest pain, or shortness of breath. Appetite unchanged. He is afebrile and in no acute distress.

**Past Medical History**
- Hyperlipidemia
- Atrial fibrillation
- Hypertension
- Benign prostatic hyperplasia
- Pre-diabetes

**Past Surgical History:** Right percutaneous nephrostomy tube placement (2/13/2026) at NYP- Weill Cornell

**Allergies:** No known allergies

**Immunization**: up to date with immunization

**Medications**

- Amoxicillin-Clavulanate 875/125 mg PO q12h for 10 days
- Diltiazem 180 mg PO daily
- Apixaban (Eliquis) 5 mg BID
- Tamsulosin 0.4 mg PO QHS
- Acetaminophen 975mg Q8H PRN for pain
- Lidocaine patch daily for pain
- Guaifenesin-DM PRN for cough

**Family History:**

Mother- deceased at an unknown age and unknown cause
Father- deceased at an unknown age and unknown cause
Maternal/paternal grandparents- deceased at unknown age and unknown reasons, no pmh.
No siblings or children

**Social history**

Mr. G.W is a 77-year-old male long-term care resident at the facility who requires assistance with some activities of daily living. He is retired and previously worked as a Banker. He denies tobacco, alcohol, or illicit drug use. He does not consume caffeine. He reports eating regular meals provided by the facility and describes his appetite as good. He states that he usually sleeps 7-8 hours per night. He has been using a walker for ambulation due to an unsteady gait and is encouraged to continue its use for safety and fall prevention. He is currently participating in physical and occupational therapy to improve strength, balance, and overall functional mobility. He denies any recent travel. He is not currently sexually active.

**Review of Systems**

**General:** Denies fever, chills, weight loss, fatigue, or night sweats. Reports fair appetite and occasional difficulty falling asleep**.**
**Skin:** Denies rashes, itching, discoloration, or wounds.
**Head:** Denies dizziness, syncope, or head trauma.
**Eyes**: reports of watery discharge. Does not wear corrective lenses. Denies pain or recent vision changes.
**Ears**: denies hearing loss, tinnitus, or discharge.
**Nose/Throat:** reported rhinorrhea, denies any sore throat, dysphagia, or voice changes.
**Neck:** Denies stiffness, pain, or masses.
**Cardiovascular:** Denies chest pain, palpitations, dyspnea, edema, syncope, or orthopnea.
**Respiratory**: reported a productive cough with clear sputum, denies any wheezing or shortness of breath.
**Gastrointestinal:** Denies nausea, vomiting, abdominal pain, diarrhea, constipation, melena, or hematemesis. Appetite fair.
**Genitourinary:** Denies dysuria, frequency, urgency, hematuria, or incontinence. History of prior obstructive 7 mm right ureteral stone, currently resolved, right Percutaneous nephrostomy placement with drainage.
**Musculoskeletal:** Reports unsteady gait and difficulty ambulating without a walker, requiring one person's assistance when ambulating or transferring from bed to chair. Reports right flank pain above

PCN placement,  rated pain as a 3/10, and describes pain as a “dull aching” sensation.  Denies swelling, stiffness, or deformity.
**Neurological:** patient is awake, alert, verbally responsive, and oriented to person, place, and time AoX3**.** Denies dizziness, weakness, numbness, tremors, or loss of consciousness.
**Endocrine:** Denies polydipsia, polyuria, polyphagia, or temperature intolerance.
**Hematologic:** Denies easy bruising, bleeding, or lymphadenopathy.
**Psychiatric:** denies anxiety,  depression, mood swings, hallucinations, or suicidal ideation.

**Physical exam**

**General:** 77 Y.O male of average build, well kept, and appears to be his stated age. Patient was found in a left lateral recombent position in bed in a long-term care facility, awake, alert, and oriented, and was verbally responsive with no acute distress.

**Vitals signs**

**Blood pressure**: Right arm, upright position: 115/64 mm Hg
Temperature: 98.4 F (oral)
**O2 sat**: 99% on room air
**Respiratory rate:** 18 breaths/min, unlabored
**Pulse**: 70 bpm, regular
**Height**: 71 inches
**Weight**: 155  lbs
**BMI:** 21.60

**Lungs:** Clear to auscultation bilaterally with mild expiratory rhonchi; no increased work of breathing.

**Cardiac:** Regularly-irregular rhythm due to A-Fib, normal heart rate, no rubs or murmur were appreciated

**Abdomen:** Soft, non-distended, non-tender. No CVA tenderness.

**GU**: Bladder non-distended. PCN bag draining dark yellow, clear urine.

**Skin:** Right PCN site with minimal sanguineous drainage; no erythema, warmth, purulence, or foul odor.

**Head:** Normocephalic and atraumatic. No scalp tenderness or lesions. Upper lip with vesicular crusted lesions

**Eyes**: EOMI, PERRLA, bilateral conjunctivitia, and watery discharge

**Neck:** Supple with a full range of motion. No lymphadenopathy, thyromegaly, or JVD. Trachea midline. No carotid bruits appreciated.

**ENMT:** Hearing normal bilateral. External auditory canals are clear. No pain or drainage. Nares patent. Positive watery nasal discharge, no obstruction, or tenderness over the sinuses. Oral mucosa with moist

membranes, fluid-filled vesicular ulcers to the upper lip with crusting, mild erythema, or no exudate. Tongue midline. Dentition fair. No difficulty swallowing observed.

**Neurological**: Mental Status: A&O x 3, cooperative, thoughts & speech coherent. Cranial Nerves: II-XII intact.

**Motor:** Good muscle bulk and tone, strength 5/5 in all extremities. No weakness in the upper and lower extremities.

**Sensory:** Pinprick, light touch, position sense, temperature, and vibratory sense intact bilaterally.

**Coordination:** Finger-to-nose intact; Gait observed to be slow and unsteady, with a mild stooped posture. Observed having a steady gait with a walker for assistance.

**Musculoskeletal System:**
No ecchymosis/ erythema/ atrophy/or deformities in bilateral upper and lower extremities. No limited ROM. No crepitus in all upper and lower extremities bilaterally.

**Imaging & Labs ordered:**

**Viral Panel**: SARS-CoV-2, Influenza A/B, RSV – Not Detected

**CBC:**

WBC: 12.94

H/H: 15.2:47

PLT: 397

**BMP:**

BUN: 24

Cr: 1.2

Na: 139

K: 4.4

Cl: 105

Glucose: 110

Ca: 9.3

**Chest X-ray**: No acute pneumonic infiltrates and pleural effusion

**Assessment**

Mr. G.W is a 77 year old male with multiple comorbidities who was evaluated for admission status post right PCN placement due to obstructive pyelonephritis secondary to a ureteral calculus, currently hemodynamically stable without signs of systemic infection. PCN site demonstrates minimal sanguineous drainage without evidence of cellulitis or purulent infection, with adequate urine output. Upper respiratory symptoms with a negative viral panel and a negative CXR are most consistent with acute viral URI. Upper lip vesicular lesions consistent with herpes labialis. Currently no evidence of recurrent pyelonephritis, pneumonia, or sepsis. Will continue to monitor for signs of infection throughout the rehabilitation center.

**Ddx:**

1. **Acute Viral Upper Respiratory Infection (URI)** – patient reports a 2-day history of productive cough with clear sputum, rhinorrhea, and watery conjunctival discharge. He is afebrile, hemodynamically stable, with normal oxygen saturation and a negative chest X-ray. The viral panel for (COVID-19, Influenza A/B, RSV) is negative, but other respiratory viruses, such as rhinovirus or adenovirus, remain possible. CBC showed a mild elevation in WBC count to 12.94, which could reflect.

2. **Acute Bronchitis** – productive cough with mild expiratory rhonchi on exam supports lower airway inflammation. However, the absence of fever, hypoxia, increased work of breathing, or radiographic infiltrates makes this likely mild and self-limited.

3. **Herpes Labialis** – vesicular crusted lesions on the upper lip are consistent with herpes simplex virus reactivation. Recent hospitalization, physiologic stress, and advanced age are likely triggers. This is likely concurrent but separate from respiratory symptoms.

4. **Atypical Pneumonia** – considered as a possible cause due to his age and mild leukocytosis. However, it is less likely due to normal vital signs, absence of hypoxia, negative chest X-ray, and lack of systemic symptoms such as fever or shortness of breath. However, Elderly patients can present atypically, so continued monitoring is warranted, especially after recent hospitalization.

**Plan:**

#Obstructive Pyelonephritis status post R PCN

- Continue Amoxicillin-Clavulanate 875/125 mg PO q12h for 10 days. Prophylaxis due to a recent PCN procedure and an elevated white count of 12.94
- Monitor nephrostomy output every shift with a gentle flush with 5 mL sterile Normal saline
- CBC, CMP, and trend for signs of infection
- Monitor vitals daily
- Urology follow-up with Dr. Gupta, NYP Weill Cornell on 2/26/2026

#Right Flank Pain (Status post PCN placement)

- Acetaminophen 975 mg PO q8h scheduled
- Lidocaine patch daily

#Unsteady Gait/Fall Prevention

- Reinforce the use of assistive devices (walker or can)
- Provide supervision during ambulation as needed
- PT/OT consult
- Environmental safety check, ensure adequate lighting, and remove trip hazards.
- Continue to monitor for delayed pain, bruising, swelling, and take Tylenol PRN for pain

#Acute Cough

- Continue Guaifenesin-DM PRN
- Encourage hydration

#Herpes Labialis

- Supportive care
- Topical ointment alycovir QID for 10 days.

#Continue management of chronic conditions: HTN, HLD, A-Fib, Pre-diabetes

#Atrial Fibrillation

- Continue Apixaban 5 mg BID
- Continue Diltiazem 180 mg daily
- Monitor Heart rate

#Hypertension / Hyperlipidemia

- Continue diltiazem
- Monitor BP

#BPH

- Continue Tamsulosin 0.4 mg QHS

#Pre-Diabetes

- Obtain 2 sets of Hb A1c to establish baseline
- Daily finger-stick glucose monitoring

Code Status: Full Code/CPR

## Patient Education

### Obstructive Pyelonephritis with Percutaneous Neohorstomy Placement:

Obstructive pyelonephritis is commonly caused by a urinary tract obstruction, such as a kidney stone, which can lead to infection. The right ureteral stone caused obstruction and required a percutaneous nephrostomy (PCN) tube placement to allow urine drainage and resolve the infection. Proper care of the nephrostomy tube is essential to prevent recurrent infection or other complications, including keeping the PCN site clean and dry and ensuring the PCN bag drains appropriately. Supportive measures, including adequate hydration, rest, and adherence to prescribed pain medications such as Tylenol or ibuprofen.

### Acute Viral Upper Respiratory Infection:

Viral infections are commonly caused by viruses such as rhinovirus and adenovirus. A productive cough with clear sputum, rhinorrhea, and watery conjunctival discharge is all fairly common to viral upper respiratory infection. With the absence of a fever or abnormal chest imaging, viral infections can cause discomfort, fatigue, and mild respiratory symptoms. Patient Supportive care includes adequate hydration to thin respiratory secretions, rest to aid recovery, symptom relief as needed, and proper hand hygiene with covering the mouth and nose when coughing to prevent spread

### Herpes Labialis:

The patient has vesicular, crusted lesions on the upper lip consistent with HSV-1 reactivation. Stress, illness, or hospitalization can trigger outbreaks. Management includes avoiding contact with the lesions, washing your hands frequently, and not sharing utensils or personal items with others.

### Red Flags / When to Seek Immediate Medical Attention:

- Fever, chills, or worsening cough
- Shortness of breath or difficulty breathing
- Chest pain or palpitations
- Confusion, sudden weakness, or altered mental status
- Coughing up blood or colored/purulent sputum
- Lesions spreading rapidly, causing pain, or involving the eyes
- Redness, swelling, increased pain, or foul-smelling drainage from the PCN site
- Decreased urine output or inability to drain urine through the PCN